

RELEASE OF INFORMATION

The following individuals, Medical Doctors, Dentists, Psychologists, Psychiatrists, Counselors, Therapists, Teachers, Coaches, Educational Consultant, Admissions Officer, or representatives of institutions who have treated, counseled, educated, or evaluated me do hereby authorize to release all information, medical history, treatment history, diagnoses, results of psychological, psychiatric, and educational evaluations, or academic records or transcripts to Q&A Associates, Inc. Staff or consultants who will be involved in my program. I do hereby authorize the staff of e Q&A Associates, Inc. to release information regarding me to any one listed below. These individuals may have worked with me, in the capacity indicated, prior to my enrollment in Q&A Associates, Inc., may be associated with a school or program to which I might apply or re-apply after completion of the Q&A Associates, Inc. A fax or photocopy of this agreement shall be deemed as effective as the original.

Name [REDACTED] Role Psychiatrist

Phone [REDACTED] Address: [REDACTED]

Name [REDACTED] Role Educational Consultant

Phone [REDACTED] Address: [REDACTED]

Name [REDACTED] Role Mental Health Therapist

Phone [REDACTED] Address: [REDACTED]

These Authorization, Release, and Consent Agreements are entered into effective 10/29/15 (date) by and between Q&A Associates, Inc. and Evan Harris the Participant, attending Q&A Associates, Inc. These agreements shall remain in effect for the entire period of my participation. I have carefully read and understood all terms of these agreements and by signing I execute them voluntarily. I further agree to accept full financial responsibility for any medical costs or fees charged by any licensed medical doctor or medical institution providing medical services to me.

Signature of Participant E Harris Date 11/29/15

Evan Harris
Printed Name

Cell Phone Number (504) 333 1625 Emergency Phone Number (504) 450 0951

Address 3720 Edenborn Ave, Metairie, LA 70002

Social Security Number [REDACTED]

Date 10/29/15

Medical Insurance Company: HMO Louisiana Inc.

Policy # [REDACTED] Group # [REDACTED]

(PLEASE PROVIDE FRONT & BACK COPY OF INSURANCE CARDS) - done